

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 001121	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 10/09/2013
NAME OF PROVIDER OR SUPPLIER BETHANY VILLAGE ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 3530 S SHELBY ST INDIANAPOLIS, IN 46227		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	<p>INITIAL COMMENTS</p> <p>This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00134366.</p> <p>Complaint IN00134366 - Unsubstantiated due to lack of evidence.</p> <p>Survey dates: October 7, 8 9, 2013.</p> <p>Facility number: 001121 Provider number: 001121 AIMS number: N/A</p> <p>Survey team: Marcy Smith, RN - TC Diana Zgonc, RN Patti Allen, SW (October 8 & 9, 2013)</p> <p>Census bed type: Residential 69 Total 69</p> <p>Census payor type: Medicaid 30 Other 39 Total 69</p> <p>Sample: 7</p> <p>Bethany Village Assisted Living was found to be in compliance with 410 IAC 16.2 in regard to the State Residential Licensure Survey and the Investigation of Complaint IN00134366.</p> <p>Quality Review 10/09/13 by Lisa McColly</p>	R 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE